

## Corporate Medical Policy

### Percutaneous Discectomy

**File Name:** percutaneous\_discectomy  
**Origination:** 9/1991  
**Last CAP Review:** 5/2011  
**Next CAP Review:** 5/2012  
**Last Review:** 1/2012

#### Description of Procedure or Service

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Percutaneous discectomy is a technique by which disc decompression is accomplished by the physical removal of disc material rather than its ablation. Originally, percutaneous discectomy was performed manually. This technique has been replaced with automated devices that involve placement of a probe within the intervertebral disc and aspiration of disc material using a suction cutting device.

Back pain related to herniated discs is an extremely common condition and a frequent cause of chronic disability. Although many cases of acute low back pain will resolve with conservative care, a surgical decompression is often considered when the pain is unimproved after a month and is clearly neuropathic in origin, resulting from irritation of the nerve roots. Open surgical treatment typically consists of some sort of discectomy, where the extruding disc material is excised. Minimally invasive options have also been researched, in which some portion of the disc material is removed or ablated, although these techniques are not precisely targeted at the offending extruding disc material. Ablative techniques include laser discectomy and radiofrequency decompression. In addition, intradiscal electrothermal annuloplasty is another minimally invasive approach to low back pain. In this technique, radiofrequency energy is used to treat the surrounding disc annulus.

#### Regulatory Status:

The Stryker DeKompressor Percutaneous Discectomy Probe (Stryker) and the Nucleotome (Clarus Medical) are examples of percutaneous discectomy devices that received clearance from the U.S. Food and Drug Administration (FDA) through the 510(k) process. Both have the same labeled intended use, i.e., “for use in aspiration of disc material during percutaneous discectomies in the lumbar, thoracic and cervical regions of the spine.”

#### Related Policies:

Intradiscal Electrothermal (IDET) Annuloplasty and Percutaneous Intradiscal Radiofrequency Annuloplasty  
Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty)

***\*\*\*Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

# Percutaneous Discectomy

## Policy

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**Percutaneous Discectomy is considered investigational for all applications. BCBSNC does not provide coverage for investigational services or procedures.**

## Benefits Application

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This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

## When Percutaneous Discectomy is covered

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Not applicable

## When Percutaneous Discectomy is not covered

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Percutaneous discectomy is considered investigational as a technique of intervertebral disc decompression in patients with back pain related to disc herniation in the lumbar, thoracic, or cervical spine.

## Policy Guidelines

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Based on a literature search from 1990 through February 2005 comparing percutaneous discectomy to either open discectomy or conservative therapy only 5 controlled trials were found. A Cochrane report published in 2000 which was not included in the 1990 BCBSA TEC assessment concluded that there was moderate evidence that percutaneous discectomy produced poorer clinical outcomes than standard discectomy. The LAPDOG study published in 2002 indicates that percutaneous discectomy lacks scientific evidence to support its effectiveness in the treatment of lumbar disc herniation.

A 2008 literature search found no new relevant studies. Freeman and Mehdian assessed the current evidence for three minimally invasive techniques used to treat discogenic low back pain and radicular pain: electrothermal therapy (IDET), percutaneous discectomy, and nucleoplasty. They report that trials of automated percutaneous discectomy suggest that clinical outcomes are at best fair and often worse when compared with microdiscectomy. At this time there is inadequate data based on controlled clinical trials to permit scientific conclusions on the effectiveness on net health outcomes.

There is insufficient evidence obtained from well-designed and executed randomized controlled trials to evaluate the impact of automated percutaneous discectomy on net health outcome.

# Percutaneous Discectomy

## Billing/Coding/Physician Documentation Information

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcbsnc.com](http://www.bcbsnc.com). They are listed in the Category Search on the Medical Policy search page.

*Applicable service codes: 62287, 0274T, 0275T, S2348*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

## Scientific Background and Reference Sources

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### **Herniated Lumbar Disc, Percutaneous**

Consultant review - 7/8/2001

Specialty Matched Consultant Advisory Panel - 8/2001

Specialty Matched Consultant Advisory Panel - 8/2002

BCBSA Medical Policy Reference Manual, 7.01.18, 4/15/02

Specialty Matched Consultant Advisory Panel - 7/2003

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.18, 4/1/2005

Specialty Matched Consultant Advisory Panel - 6/2005

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.18, 3/7/2006

Specialty Matched Consultant Advisory Panel - 5/2007

Freeman BJ and Mehdiian R. Intradiscal electrothermal therapy, percutaneous discectomy, and nucleoplasty: what is the current evidence? *Curr Pain Headache Rep* 2008; 12(1):14-21.

### **Percutaneous Lumbar Discectomy**

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.18, 11/13/08

Specialty Matched Consultant Advisory Panel - 5/2009

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.18, 2/10/11

Specialty Matched Consultant Advisory Panel – 5/2011

### **Percutaneous Discectomy**

# Percutaneous Discectomy

Medical Director 8/2011

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.18, 11/10/11

## Policy Implementation/Update Information

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### Percutaneous Lumbar Discectomy

7/6/09 "Herniated Lumbar Disc, Percutaneous" policy separated into individual policies by topic. Percutaneous Lumbar Discectomy is considered investigational. Specialty Matched Consultant review 5/28/09. No change to policy statement. "Description" revised. Rationale updated in "Policy Guidelines" section. References added. (btw)

6/22/10 Policy Number(s) removed (amw)

6/21/11 Specialty Matched Consultant Advisory Panel review 5/25/2011. "Description" revised. No changes to policy intent. References added. (btw)

### Percutaneous Discectomy

8/16/11 "Lumbar" removed from title and throughout policy as appropriate to include percutaneous discectomy for all spinal levels. Added CPT 0274T and 0275T to "Billing/Coding" section. Medical Director review 8/2/2010. (btw)

1/24/12 Added HCPCS code S2348 to Billing/Coding section. Reference added. (btw)

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Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.